CHILD CARE APPLICATION

Eastern Shawnee Tribe of Oklahoma
Please Print

Name of Family Requesting Services _____

Street Address:_____ City: _____ State: _____ Zip: _____

Mailing Address: _____City: _____ State: _____ Zip: _____

Home Telephone: (_____)_____ Business Telephone: (_____)_____

Employer(s): _____Tribal Affiliation: _____

Have services been utilized from any other Tribal CCDF Program? _____

If so what Tribe _____

PEOPLE RESIDING IN HOUSEHOLD

First Name	MI	Last Name	SEX	DOB	SS#	Marital Status

Provider Information

Daycare: _____

Address: _____

City, State:_____

Zip:_____Phone #:_____

Applicant's Signature:_____

Date Signed: _____

Co-payment Amount: _____

Maximum Days Authorized: _____
Dates Certified_____

CHILD INFORMATION

Child's Name _____ Sex ____ DOB _____

SS# _____ Tribal Affiliation _____

CDIB/Membership Card _____Yes _____No   If pending, date of application_____

Provider _____ Effective Date _____

Child's Name _____ Sex ____ DOB _____

SS# _____ Tribal Affiliation _____

CDIB/Membership Card _____Yes _____No   If pending, date of application_____

Provider _____ Effective Date _____

Child's Name _____ Sex ____ DOB _____

SS# _____ Tribal Affiliation _____

CDIB/Membership Card _____Yes _____No   If pending, date of application_____

Provider _____ Effective Date _____

Do any of your children have special needs? ____Yes ____ No

Special Needs Documents Attached _____Yes ____ No

If yes, explain _____

I AFFIRM UNDER PENALTY THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF AND UNDERSTAND THAT ANY FALSE STATEMENTS ON MY PART MAY RESULT IN PROSECUTION FOR FRAUD AND REAPYMENT TO THE PROGRAM AND IS PUNISHABLE BY FINE OR INPRISONMENT. THE INDIVIDUAL(S) NAMED IS/ARE AND APPLICANT FOR CHILDCARE ASSITANCE PROGRAM, WHICH IS SUBSUIDIZED THROUGH THE EASTERN SHAWNEE TRIBE OF OKLAHOMA. FEDERAL REGULATIONS REQUIRE THAT IN ORDER FOOR THE INDIVIDUAL(S) TO BE ELIGIBLE AND OR MAINTAIN ELIGIBILTY, WE MUST VERIFY THE INDIVIDUAL(S) INCOME AND OTHER INFORMATION RELAEASE FORM. THE INFORMATION YOU PROVIDE WILL BE USED ONLY FOR THE PURPOSE OF DETERMINING THE INDIVIDUAL(S) AND OR CONTINUED ELIGIBILITY FOR THE PROGRAM. WE ARE REQUIRED TO COMPLETE OUR VERIFICATION PROCESS IN A SHORT TIME PERIOD AND WOULD APPRECIATE YOUR PROMPT RESPONSE. IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO CONTACT OUR OFFICE. THANK YOU FOR YOUR COOPERATION.

_____

Parent Signature   Date